King County Health Action Plan's Community Benefits Program
Three-Year Program Summary
May 2002

The organizations that make up the health care system in King County have a long history of providing important services that benefit the community beyond simply delivering health care services. Fearing that with the acutely competitive and price-sensitive nature of today's health system there could over time be a decrease in the level and the quality of these community benefits, the Health Action Plan began a dialog with these organizations in 1997. Key drivers of this dialog were that hard data can move voluntary action and that coordination of collective community giving focused on a few prioritized areas of need would amplify any one organization's individual effort.

The result was the Health Action Plan's Community Benefits Program. For purposes of this program, community benefits is defined as a service that responds to community needs or priorities and that is designed to affect the community as a whole, beyond the benefit to the individuals who may be served or to the individuals providing the service. The Community Benefits Program has been operational for three years beginning in 1999 and extending through the end of 2001. The following report will provide a background on project activities for the past three years and a summary of the program's funding levels, lessons learned, outcomes and achievements.

Background

The Community Benefits Program prioritized its attention on worsening health trends affecting vulnerable populations living in King County. Data collected and analyzed by Public Health - Seattle & King County was used to identify the following three worsening health trends: childhood asthma, diabetes among African Americans, and breast and cervical cancer among Asian women. Four community-based projects emphasizing prevention strategies and targeting these worsening trends were selected to be the recipients of Community Benefits Program funding. The four projects receiving funding for the past three program years are the Asthma Outreach Program at the Odessa Brown Children's Clinic, the Community Diabetes Initiative, the African American Elders Project, and the Breast and Cervical Health Program at International Community Health Services (ICHS). In 2000, at the request of the design committee many of whom were also members of the Community Benefits Program a second diabetes project, Community Connections for Chronic Disease, was added as a project option to which to designate funding.

Community Benefits Participating Organizations and Funding Levels

The Community Benefits Program maintained a core group of contributors from 1999-2001. Member organizations for each project year are outlined below:

1999	2000	2001
Aetna US Healthcare	Children's Medical Center	Children's Medical Center
Community Health Plan of WA	Community Health Plan of WA	Community Health Plan of WA
First Choice Health Network	First Choice Health Network	First Choice Health Network
Group Health Community Foundation	Group Health Community Foundation	Group Health Community Foundation
PacifiCare of Washington	PacifiCare of Washington	PacifiCare of Washington
Regence Blue Shield	Regence Blue Shield	Premera Blue Cross
Swedish Health Services	Premera Blue Cross	Swedish Health Services
	Swedish Health Services	Virginia Mason Medical Center
	Virginia Mason Medical Center.	

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The collective funding level of the Community Benefits Program for each program year is as follows:

1999	2000	2001	Total
$45,500	$57,685	$59,320	**$162,505**

In-kind contribution of King County Health Action Plan:[1]

1999	2000	2001	Total
$5,460	$6,922	$7,118	**$19,500**

Total funding contributed by the Community Benefits Program:

1999	2000	2001	Total
$50,960	$64,607	$66,438	**$182,005**

The core organizations that comprise the Community Benefits Program made a three-year commitment to help support five community-based projects. In doing so, these organizations were able to collectively have more impact with their contributions than any one organization acting on its own. Each year saw an increase in the total amount contributed with a three-year total of $162,505.

Each of the Community Benefits members were provided the choice to either designate their contribution to one or more of the four projects or have their contribution undesignated. Over the three-year funding cycle the contributions to each of the four projects were as follows:

Community Diabetes Initiative:

1999	2000	2001	Total
$15,000	$24,195	$27,568	**$66,763**

Odessa Brown's Asthma Outreach Project:

1999	2000	2001	Total
$15,000	$10,490	$19,752	**$45,242**

ICHS's Breast and Cervical Health Program:

1999	2000	2001	Total
$10,500	$6,000	$8,000	**$24,500**

The African American Elders Project:

1999	2000	2001	Total
$5,000	$6,000	$2,000	**$13,000**

Community Connections for Chronic Disease Project:

1999	2000	2001	Total
$0	$11,000	$2,000	**$13,000**

[1] Total of indirect costs @ 12% assessed on Health Action Plan budget by Public Health - Seattle & King County as a function of Community Benefits revenue and contracts. Totals do not represent Health Action Plan staff time.

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Three-year Summary of Funded Project's Outcomes and Achievements

Beginning in 1999 the Community Benefits Program of the King County Health Action Plan has provided funding in support of five community-based projects working in the areas of diabetes, childhood asthma, and breast and cervical cancer among Asian women. The five projects are the Breast and Cervical Health Program at International Community Health Services (ICHS), the Community Diabetes Initiative, the Asthma Outreach Program at Odessa Brown Children's Clinic, African American Elders Project, and Community Connections for Chronic Disease targeting diabetes.

Over a three-year period, 1999-2001, members of the Community Benefits Program have voluntarily contributed $162,505 to help these projects sustain, and in some cases expand, their services. The following summary outlines the funding levels, outcomes, and achievements for the three program years for each project:

1. Breast and Cervical Health Program/International Community Health Services (ICHS)

1999 Funding Level: $10,500 contributed with funds specifically directed toward an outreach worker to connect Asian women (primarily Vietnamese women) to breast and cervical cancer screening services at ICHS.

1999 Outcomes/Achievements: The funds contributed to ICHS paid for 700 hours of an outreach worker's time. In 1999, this helped to facilitate the screening of 1,086 women for breast and cervical cancer (728 annual returns and 358 newly enrolled). Of these women served, 20 % were Vietnamese.

2000 Funding Level: $6,000 contributed by Community Benefits partners. Funds were directed toward continued support of an outreach worker to connect Asian women to breast and cervical cancer screening services at ICHS.

2000 Outcomes/Achievements: There were 1241 women served through the breast and cervical health program at ICHS in 2000 (956 annual returns and 213 newly enrolled). Of these women served, 17 % were Vietnamese.

2001 Funding Level: $8,000 contributed by Community Benefits Program to be directed toward staffing of an outreach worker to connect Asian women to breast and cervical cancer screening with a focus on Asian/Pacific Islander populations newly identified as at risk.

2001 Outcomes/Achievements: A total of 1465 women were served in the Breast and Cervical Health Program at ICHS in 2001 (1025 annual returns and 440 newly enrolled). Of these women, 19% were Vietnamese.

2. Community Diabetes Initiative/Puget Sound Neighborhood Health Centers

1999 Funding Level: $15,000 was contributed by the Community Benefits partners with $5,000 targeted to providing eleven patients' annual diabetic supplies and $10,000 for partial funding of a registered nurse to provide diabetic self-management support.

1999 Outcomes and Achievements:

Measure	Definition of Measure	Goal	CDI (as a whole)
1. Glycemic control	% of patients with one HbA1C result < 8 within the past year	40%	47%

2. Glycemic monitoring	% of patients with HbA1c in last 6 months	90%	65%
3. Access to supplies	% with documented access to glucose monitoring supplies	0%	100%
4. Access to self-management support	% with at least one documented session of diabetic education or counseling annually	50%	43%

2000 Funding Level: $17,000 contributed by Community Benefits partners and $7,195 HCFA matching funds for a total of $24,195 for partial support of project coordinator position and Self-Management Support Consultant.

2000 Outcomes:

- Glycemic control: 52 % of clients throughout the network of CDI community clinics had HbA1c below 8% (as compared to 39% in 1999)
- Total number of diabetic clients on the CDI registry continues to increase and is now over 4000
- Self-Management Support Consultant trained provider staff at all CDI participating clinics in techniques of self-management support

2001 Funding Levels: $17,000 contributed by Community Benefits partners and $10,568 HCFA matching funds for a total of $27,568 for partial support of project coordinator position.

2001 Outcomes and Achievements:

Measure	Definition of Measure	Goal	CDI
1. Glycemic control	% of patients with one HbA1C result < 8 within the past year	40%	55%
2. Glycemic monitoring	% of patients with 2+ HbA1c 91 + days apart	90%	54%
3. Established self-	self-management goal Identified and documented	50%	22%[2]
4. Total # on registry	4293		

[2] While some of the participating CDI clinics are near the 50% goal on this measure, others who do poorly pull the average down. Two reasons cited for why some clinics do poorly are cultural challenges when assisting some ethnic populations to identify self-management goals, and pressures on time that prevent staff from updating documentation in the registry.

3. The Asthma Outreach Project/Odessa Brown Children's Clinic

1999 Funding Level: $15,000 was contributed by the Community Benefits partners with funds targeted for 0.5 FTE outreach worker, or 0.7 FTE medical assistant/clerical support, or 0.15 FTE physician resource.

1999 Outcomes/Achievements
Project Goals:
Asthma Outreach Project Clinical Quality Indicators[3]:

1. All Asthma patients should have their severity level documented at least once a year.
2. Patients with persistent asthma should have an anti-inflammatory prescribed in the last year.
3. Patients with persistent asthma and perennial symptoms should receive sensitivity testing for indoor airborne allergens
4. Patients with persistent asthma should have scheduled follow-up visits at least two times a year.
5. Patients with persistent asthma five years and older should have spirometry checked at least once a year
6. Patients with persistent asthma should have a written management plan, and a current copy should be in their medical record.

Other 1999 Outcomes/Achievements:

	Pre-Year	Funded Year	% Change
Asthma Outreach Project Data:			
Clinic Enrollment	2351	2504	+6.5
Asthma Hosp. Frequency	35	25	-28.6
Asthma Hosp. Frequency (single admits)	23	16	-30
Asthma Hosp. Rate	1.5%	1.0%	-33.3%*
Children's Hosp. Data:			
Census	11,348	11,676	+2.9
Asthma Hosp. Frequency	753	785	+4.2
Asthma Hop. Rate	6.6%	6.7%	+1.5

*The AOP enrolled children have demonstrated a significant decline in rates of hospitalization from pre-funding period to present. During this same time period rates of asthma hospitalization at Children's Hospital increased.

2000 Funding Level: $6,500 contributed by Community Benefits partners and $3,990 HCFA matching for a total of $10,490 in support of an asthma outreach worker.

[3]The Asthma Outreach Project did well on these indicators. This data has been given to Community Benefits members in the past, but if you would like another copy on can be provided.

2000 Outcomes/Achievements: Patients in the Asthma Outreach Project that were hospitalized during the past year had shortened hospitalizations. There was a predominance of one clinic visit per year for enrolled children. With the implementation of the new asthma registry, collection of accurate data will be enhanced as will the ability to better track clinic visits and increase visits to an optimum 2-3 per year.

2001 Funding Levels: $12,000 contributed by Community Benefits partners and $7,752 HCFA matching for a total of $19,752 in support of an asthma outreach worker.

2001 Outcomes/Achievements:
Tracking procedures: We report the use of two procedures in calendar year 2001as quality indicators: pulmonary function testing (spirometry) and skin testing. 112 children underwent pulmonary function testing, skin testing or both. Of these, 97 children underwent pulmonary function testing a total of 155 times, or 1.6 spirometry visits per child and 21 children were skin tested. In general, children who are five years or older perform spirometry when they come to a planned asthma visit. This information is used for severity classification, monitoring therapeutic response, and as a teaching tool to reinforce adherence to regular use of preventive medication. In contrast, children are typically skin tested just once, to guide environmental mitigation efforts, which accounts for the low number of these procedures in comparison to spirometry.

Clinic Activity: The Asthma Outreach Project holds an asthma clinic twice a month, as well as occasional Saturdays and several clinics in late August, in preparation for the school year.

The number of patients involved with the Asthma Outreach Project has grown nearly ten-fold since its inaugural year (1995), when we offered these services to 24 children and their families. This year we had 529 clinic visits for asthma. Over ¾ of these, 79.8%, were for planned asthma care, and 20.2% were for acute visits.

From the perspective of the patients themselves, these visits were made by 240 children. Most (168) of these children came in for preventive asthma care only, although 26 children "slipped through our net", coming in for acute asthma care only. There were 46 children who had visits for both acute and preventive asthma care.

4. African American Elders Program/Senior Services

1999 Funding Level: $5,000 was contributed by the Community Benefits partners targeted toward partial support of project staff to provide health services, diabetic patient education, and nutritional counseling.
1999 Outcomes/Achievements: The 1999 Community Benefits contributions partially supported an eight -week diabetes/nutrition awareness and education workshop which connected 21 isolated, elderly diabetic African Americans to important health and social services.
2000 Funding Level: $6,000 was contributed by the Community Benefits partners for partial support of the project coordinator position.
2000 Outcomes/Achievements: Served 1,500 senior clients; served 590 new African American clients; 596 African Americans who increased their utilization of appropriate community

services; 85 African Americans followed for comprehensive case management and health services; 115 Community Meetings, Forums, and Health Fairs; 21,487 people who received program information.
2001 Funding Level: $2,000 was contributed for support of an outreach worker to help connect elderly, diabetic African Americans living in the community to important health services.
2001 Outcomes/Achievements: Served 1,063 senior clients in 2001;served 626 new African American; 552 African Americans who increased their utilization of appropriate community services; 108 elderly African American attendees at Health Fairs, Community Meetings and Forums; 8,663 people who received program information; provided breast health education to over 2,543 women and screened 223 women for breast cancer via the Providence Mobile Mammography Unit.

5. Community Connections for Chronic Disease

2000 Funding Levels: $11,000 was contributed to implement the Community Connections Project in partnership with Community Health Centers of King County.
2000 Outcomes and Achievements: Project Nurse conducted case management of clients (total number averaged approximately 157) on diabetes registry at Auburn Community Health Center. Clients contacted and referred based on the following criteria: 77 clients referred who had no eye exam in past 12 months; 94 clients referred who had no foot exam in past 12 months; 66 clients with HbA1c greater than 8% contacted and advised to schedule an appointment with their PCP; 32 clients with no clinic visit in the last 180 days contacted and advised to make an appointment with their PCP.
2001 Funding Levels: $2,000 for support of Community Connections Project in partnership with Community Health Centers of King County.
2001 Outcomes and Achievements: Project Nurse provides case management of diabetic clients on diabetes registry at Federal Way Community Health Center (approximately 177 clients). After 6 months the following data has been collected: 92 patients with HbA1c greater than 9.5% or blood pressure greater than 140/90 were contacted with the specific aim to connect with a provider for diabetes education, self-management goal setting and other relevant services. After 6 months, among this group of 92 clients, the average HbA1c went down by .6%-a significant reduction in 6 months (a 1% reduction will significantly alleviate or delay 25%-50% of long-term diabetic complications). Additionally, systolic blood pressure was lowered by 9.22 and diastolic blood pressure was lowered by 4.61; in 6 months the number of clients with no visit for the past 12 months was reduced from 69 to 1; percent of clients having their blood pressured measured and documented went from 70 % to 94%; the percent of clients receiving diabetes education went from 52% to 70 %; and the number of clients who set a self-management goal went from 48% to 64%.

Lessons Learned

- The Community Benefits Program model that focuses community giving around hard data identifying worsening health trends assures organizations that their charitable contributions will have the greatest impact in addressing genuine health problems in our community with a population-based approach. The program has been nationally recognized as an innovative model providing the opportunity for managed care organizations and other health care

- entities to work together to address serious health issues by following the direction suggested by public health data.
- By selecting community-based projects already addressing identified worsening health trends in King County, the Community Benefits Program has been able to resourcefully add to these existing efforts to reduce poor health outcomes experienced by many of our County's most vulnerable populations. The collective funding provided to the projects by the Community Benefits Program over the past three years has assisted each of the projects to sustain, and in some cases to expand their services.
- As a function of administering this project, the Health Action Plan has contributed staff time beginning in 1997 with program development. Additionally, unanticipated indirect costs assessed against the Health Action Plan budget as a result of Community Benefits' revenues and contracts over a three-year period have totaled approximately $19,500 and presents a budgeting challenge for the future.
- The Community Benefits timeline has not aligned well with every organization's funding cycle which may present accounting difficulties to overcome when attempting to work collectively with multiple organizations to bundle collective community giving. Adjustments for accommodating this will be examined.

Future of the Community Benefits Program: Recommendations

The model of the Community Benefits Program in which health care organizations work together to collectively support population-based care addressing worsening health trends in King County has been nationally recognized. In *American Medical News,* Dr. Mohammad Akhter, Executive Director, American Public Health Association, states, ". . .**the willingness of managed care to invest in population-based care puts the Health Action Plan ahead of the rest of the nation. This is the kind of thing we'd like to see across the country."**

Given the success of this innovative model, it is proposed that the Community Benefits Program continue with the following recommendations:

- Current Community Benefits Program members will examine new Public Health data identifying worsening health trends in King County and select compelling trends as a focus for their charitable efforts.
- If new trends are chosen, community-based projects already at work in the community in these areas will be selected to be the recipients of Community Benefits Program funding efforts.
- A new option for funding support is the Health Action Plan's new Kids Get Care (KGC) Project. This project is an integrated early intervention, structured approach providing low income, uninsured and underinsured children in King County with preventive oral, physical and developmental health care services through attachment to a health care home. Through this single portal, significant amplification of achievement can be attained. KGC is poised to receive a second year of funding from HRSA and from the WDSF for continuation and amplification of this multi dimensional program.
- The Health Action Plan's Community Connections for Chronic Disease targeting diabetes is has received partial funding from the Community Benefits Program for two years. This

project assisting provider groups to case manage their diabetic patient population has been operational at the Auburn and Federal Way Community Health Centers. Preliminary

- outcome data shows improvement in critical indicators such as hemoglobin A1c, blood pressure, scheduled non-acute clinic appointments, self-management goals identified, and diabetes education received.
- Expand the base of Community Benefits members to include additional health care organizations and pharmaceutical companies.
- 12% of contributed funds will be retained in the Health Action Plan's budget to cover indirect costs (the Health Action Plan paid out approximately $19,500 in overhead costs over three years resulting from the Community Benefits Program).